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ABSTRACT

This document summarizes a review of the health problems of blacks in New York. The review comprises the first volume of a study of the needs of the two million blacks in New York. The health status of blacks is examined in each of the following phases of the life cycle: (1) maternal; (2) infancy; (3) childhood; (4) adolescence; (5) adulthood; and (6) the elder years. Related issues of services, access to and availability of medical care, and affirmative action to increase the number of medical and health care professionals to serve the black community are also reviewed. The following preliminary findings are outlined: (1) the health status of blacks has improved substantially in the past 5 years, but significant disparities continue to exist between blacks and other New Yorkers; (2) there is a clear connection between poverty and poor health, with a complex interaction of socioeconomic and behavioral factors adversely affecting the health and longevity of blacks; (3) blacks of all ages are grossly overrepresented among the poor; (4) New York State has a much higher proportion of its poverty population concentrated in poverty areas than does the nation as a whole; (5) the black poor are massed in urban areas which have substandard, overcrowded housing and adverse environmental conditions; (6) black communities have reduced access to preventive health services and to acute and long-term care; and (7) living conditions appear to be connected to the disproportionately high rates of low birthweight, infant mortality, chemical dependence, lung cancer, and cardiovascular disease among blacks. Recommendations for improvement are suggested. (FMW)

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VOLUME 1
HEALTH

BLACK HEALTH ISSUES IN NEW YORK STATE

CONDITION PROGNOSIS PRESCRIPTION

ED313472

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EXECUTIVE SUMMARY

PRELIMINARY REPORT
HEALTH SUBCOMMITTEE

THE GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS
JULY 1987

MARIO M. CUOMO
GOVERNOR

BERNARD L. CHARLES
CHAIRMAN

ROBERT T. SIMMELKJAER
EXECUTIVE DIRECTOR

UD027117

STATE OF NEW YORK
GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

July, 1987

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ALBANY, NY 12224

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NEW YORK, NY 10047

Dear Governor Cuomo:

I am pleased to forward to you the Health Subcommittee preliminary report, BLACK HEALTH ISSUES IN NEW YORK STATE: CONDITION, PROGNOSIS AND PRESCRIPTION.

The Health Subcommittee of leading experts examined the impact of a broad range of behavioral, societal and health care issues on the more than two million Blacks in New York State, home of the nation's largest Black population.

Our multidimensional approach examines the health status of Blacks at every stage of the life cycle as well as the related issues of access and availability of medical care and health manpower.

Our preliminary findings show that while the health and longevity of Blacks in the Empire State has improved substantially, disturbing disparities continue to exist as compared to other New Yorkers.

The pernicious link between poverty and poor health among Blacks is clearly established in our report.

Some 26 percent of the Black families in New York State live below the poverty line. More than half of the Black population is concentrated in urban areas, where housing is substandard, schools overcrowded and environmental conditions hazardous. Their neighborhoods are plagued by crime, drug abuse, interpersonal violence and other detrimental lifestyles. Poor diets and malnutrition pervade, communicable diseases run rampant, health services scarce.

These harsh human circumstances would make anyone sick -- and they are devastating the increasing number of poor Black New Yorkers.

The Health Subcommittee report reviews the several State programs and policies that serve well the critical health needs of Black New Yorkers and makes recommendations on the complex of issues in the accessibility, availability and quality of health care services Statewide.

Among the many strategies offered are the further affirmative actions the State must take to increase the number of health care professionals to directly serve the Black community.

The many initiatives set forth by the Health Subcommittee can serve to place New York State in the forefront of what must be a national effort to ensure equity in health care for all, regardless of race or economic circumstance.

I am confident that you will find the report useful in the formulation of State policies and programs that will further advance this important social objective.

Respectfully submitted,

Bernard L. Charles

Bernard L. Charles
Chairman

State of New York

Executive Chamber

No. 66

EXECUTIVE ORDER

ESTABLISHING A GOVERNOR'S ADVISORY COMMITTEE FOR BLACK AFFAIRS

WHEREAS, members of the Black community have contributed significantly to the State and its government to the benefit of all of the people in the State; and

WHEREAS, the State must continue to be responsive to the special needs and concerns of its Black residents; and

WHEREAS, a mechanism must be established to ensure that members of the Black community have opportunities to participate in all levels of government;

NOW, THEREFORE, I, Mario M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and the Laws of the State of New York, do hereby order as follows:

I. Governor's Advisory Committee for Black Affairs

There is hereby created a committee to be known as the Governor's Advisory Committee for Black Affairs (the "Committee"). The members of the Committee shall be appointed by the Governor. A chairperson and vice chairperson shall be designated by the Governor. The members of the Committee shall receive no compensation, but shall be entitled to reimbursement for any necessary expenses incurred in connection with the performance of their duties. The Governor shall designate an executive director of the Committee who shall be responsible for its administrative functions.

II. Purpose and Responsibilities of the Committee

1. The Committee shall identify and evaluate areas of particular concern to the Black community and submit recommendations to the Governor for his review. The Committee shall place special emphasis on the following areas:

a. development of increased opportunities for involvement of Blacks in all aspects of State government.

b. coordination of resources to create effective educational, vocational and health training programs.

c. evaluation of policy decisions affecting the Black community.

d. evaluation of programs and services provided by State agencies and their impact on the Black community.

e. development of awareness programs to assist members of the Black community in identifying and participating in programs sponsored by the State and local governments.

2. The Committee shall create a panel, whose members shall be designated subject to the approval of the Governor, to address the unique concerns of the Black family, with particular emphasis on households headed by Black women. The Commissioner of Human Rights, the Director of the Women's Division and the Executive Director of the Council on Children and Families or their designees shall provide assistance and advice to the panel.

3. The Committee shall establish subcommittees, which shall make recommendations concerning the special needs of various Black cultural and ethnic populations, including the Caribbean community. Such subcommittees shall periodically submit reports to the Committee for its consideration and adoption.

4. The Committee, in conjunction with the Governor's Executive Committee for Affirmative Action, shall review the implementation of affirmative action programs designed to increase employment opportunities for Blacks in State government.

5. The Committee shall report on a regular basis to the Governor on its activities.

6. The Committee may request and shall receive from any department, division, board, bureau, commission or agency of the State such assistance and data as will enable it to carry out its purpose and responsibilities hereunder.

G I V E N under my hand and the Privy Seal of the State in the City of Albany this fifth day of June in the year one thousand nine hundred eighty-five

(L.S.)

/s/ Mario M. Cuomo

BY THE GOVERNOR

/s/ Michael J. Del Giudice
Secretary to the Governor

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EXECUTIVE DIRECTOR

July, 1987

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NEW YORK, NY 10047

Dear Chairman Charles:

We are pleased to submit to you the Preliminary Report of the Subcommittee on Health of the Governor's Advisory Committee for Black Affairs. This Subcommittee of seventeen members, appointed by you in May 1986, has met at approximately monthly intervals.

The issues identified during our deliberations and presented in this Preliminary Report are of critical concern to the health and longevity of Black New Yorkers.

The Subcommittee has examined the impact of a broad range of behavioral, societal and health care issues and current State programs. The Report focuses on persistent disparities in health status between Blacks and other New Yorkers. The particular influences of poverty and racism on health and care are recurrent themes.

The Subcommittee is offering an extensive series of policy and programmatic recommendations which, if implemented, we are confident will improve the health status and health services delivery for Blacks in New York State.

The Final Report of the Subcommittee on Health will include comments on the Preliminary Report which will be widely circulated and reviewed at statewide hearings. These are intended to solicit community response and participation in our process.

It has been a privilege to be associated with such a hardworking and dedicated group, whose members gave so generously of their time and expertise. The Subcommittee joins us in acknowledging our great appreciation for the contributions and support of the research staff, Ruth C. Browne and Charleen Ward.

On behalf of the Subcommittee we wish to express our appreciation for the opportunity to examine these health and health-related issues.

Sincerely,

Charles Felton, Co-Chair

Judith Jones, Co-Chair
Subcommittee on Health

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ACKNOWLEDGEMENTS

The Subcommittee wishes to acknowledge with gratitude the contributions of many individuals whose information and knowledge of the issues assisted us in the formulation of this report. Particular appreciation is expressed to:

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Dr. JoAnn Bradley, Dean of the College of Health Related Professions at SUNY Health Science Center at Brooklyn, has held numerous academic and clinical positions and is a consultant for several health and health-related institutions, including Empire State College of the State University of New York and the Veterans Administration Hospital in Brooklyn. A member of numerous professional organizations, Dr. Bradley currently serves as Conference Chairperson for the Conference on Allied Health Professions Education. Dr. Bradley received her Ed.D. from Columbia Teacher's College and has developed several innovative and exemplary child care provider programs.

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Dr. Gerald Deas is an attending physician at Jamaica Hospital and an Associate Professor in the Department of Preventive Medicine at SUNY Health Science Center at Brooklyn. He is a specialist in ambulatory care and practices at Carter Community Health Center in Queens. Dr. Deas is the founder of the Sickle Cell Victims Organization, Inc. He is a health commentator on several television (The McCreary Report, WNEW Channel 5 TV) and radio (WBLS, WLIB, WWRL, WABC) programs and has written extensively on iron deficiency anemia, laundry starch ingestion, abortion, smoking, alcoholism, sickle cell anemia and a wide range of health-related issues. An expert in the area of preventive medicine, Dr. Deas received his M.D. from Downstate Medical College.

CHARLES P. FELTON

Dr. Charles Felton is the Acting Director of Medicine for the Harlem Hospital Center. He is also a Clinical Professor of Medicine in the College of Physicians and Surgeons at Columbia University. The Secretary Elect and member of the Board of Directors of the American Lung Association, he also serves on the Medical Advisory Committee of the Greater Harlem Nursing Home. Dr. Felton is an internal medicine and pulmonary specialist and has published extensively in the area of tuberculosis research. He received his M.D. from the University of Geneva.

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Judith Jones is the Director of the National Resource Center for Children in Poverty. Formerly Deputy Director of the Center for Population and Family Health and Associate Clinical Professor of Public Health, Faculty of Medicine, Columbia University, Ms. Jones has served on numerous boards and committees and is currently serving on the corporate boards of the U.S. Committee for UNICEF, Planned Parenthood Federation of America and the Center for Population Options. Her professional affiliations include membership on the panel on Adolescent Pregnancy and Childbearing of the National Research Council of the National Academy of Sciences and the Adolescent Health Task Force of the American Public Health Association. Ms. Jones received her M.S. in Business Policy from Columbia University.

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Dr. George Lythcott is Dean of the School of Medicine at the City University of New York. He also serves as Dean of the Sophie Davis School of Biomedical Education of the City College of New York. Dr. Lythcott is a former Professor of Pediatrics at the University of Wisconsin in Madison, where he held the Edward Jenner Professorship in International Health. He also served as the Director of the Center for International Resources and Services. Under the Carter Administration, Dr. Lythcott was the Administrator of the Health Services Administration for the Department of Health and Human Services. He also served as Assistant Surgeon General and Associate Chief Medical Officer for the U.S. Public Health Service. Dr. Lythcott serves on the Medical Advisory Task Force of the U.S.A. for Africa Foundation and has published extensively on both national and international health issues. He received his M.D. from Boston University.

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Eugene McCabe is President and Chief Executive Officer of North General Hospital in Harlem. Prior to this, Mr. McCabe was Regional Director for Deleuw Cathers/Parsons and Associates in New York. He served as Staff Director for the Citizen's Mobilization Unit created by former Governor Carey of New York State and was previously associated with Booz, Allen and Hamilton, Inc. Mr. McCabe is a board member of the United Mutual Life Insurance Co. Inc., Harlem Urban Development Corporation, Stillman College and the Board of Governor's of the Greater New York Hospital Association. Mr. McCabe is a graduate of Southern Connecticut State University in New Haven.

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Carole Morris has served for ten years as Executive Director of the Mount Vernon Neighborhood Health Center. She is the immediate Past President of the Community Health Care Association of New York State and serves on the Legislative and Medical Malpractice Committees of the National Association of Community Health Centers. Ms. Morris received her B.S. from Columbia University.

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Leith Mullings is an Associate Professor at the City University of New York Medical School and Department of Anthropology of the City College. In addition, she serves as Director for the Medical Anthropology Program. Dr. Mullings has taught anthropology, cross-cultural issues and urban studies at numerous universities, including the University of Dar-es-Salaam, Yale and Columbia. Extensively published, she is the author of Therapy, Ideology and Social Change: Mental Healing in Urban Ghana and editor of The Anthropology of Urban America. Dr. Mullings serves as President of the Metropolitan Medical Anthropology Association. She received her Ph.D. in Anthropology from the University of Chicago.

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Helen Murray is an Assistant Professor in the Department of Nursing at Medgar Evers College of the City University of New York. She has held numerous academic positions in nursing education, among these Senior Nurse Teacher and Curriculum Consultant for Medical Aide Training Schools in New York. Ms. Murray currently holds the office of Second Vice President in Chi, Eta, Phi Sorority, Inc., an international nursing sorority. She is currently enrolled in the graduate program in nursing education at Teachers College of Columbia University and received her M.S. in nursing from Hunter College, City University of New York.

MURIEL PETIONI

Dr. Muriel Petioni, a practicing physician in the Harlem community, is a General Practioner and Clinical Professor of Pediatrics at Harlem Hospital Center. Dr. Petioni is Founder and First Chairperson of the Susan Smith McKinney Steward Medical Society. She is a member of a number of civic and professional organizations and advocacy groups, including Delta Sigma Theta Sorority, the Coalition of 100 Black Women and New York City Department of Health Child Health Forum. Dr. Petioni received her M.D. from Howard University.

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Dr. Beny Primm is the Co-founder and Executive Director of the Addiction Research and Treatment Corporation (A.R.T.C.) in New York and an attending physician at Harlem Hospital. A specialist in drug abuse and Acquired Immune Deficiency Syndrome (AIDS) research, Dr. Primm has served as advisor to the President's Advisory Council on Drug Abuse Prevention and the Special White House Briefing Team on Drug Abuse. Dr. Primm received his M.D. from the University of Geneva.

FRANCES THORTON POE

Frances Thorton Poe is the Director of Social Work Services at North General Hospital in Harlem. The former Director of Social Work Services for Bellevue Hospital, Ms. Poe has taught social work courses at Hunter College and New York University. She is a member of a number of professional organizations and the Society of Hospital Social Work Directors of the American Hospital Association. Ms. Poe has published in Social Casework and the Journal of the American Association of Medical Colleges. She received her M.S.W. from Columbia University.

JEANNE A. SMITH

Dr. Jeanne Smith is President of the Medical Board of Harlem Hospital where she is also an attending physician and Director of the Comprehensive Sickle Cell Center. Dr. Smith is a Clinical Associate Professor of Medicine at Columbia University and serves on several faculty committees. Dr. Smith has published extensively on sickle cell disease, genetic counseling and tuberculosis. A member of several professional and health organizations, she serves on the Board of Directors of the National Association for Sickle Cell Disease. Dr. Smith received her M.D. from New York University.

GERALD E. THOMSON

Dr. Gerald Thomson is Executive Vice President for Professional Affairs at the Presbyterian Hospital. The Samuel Lambert Professor in Medicine in the College of Physicians and Surgeons of Columbia University, Dr. Thomson is a member of the New York State Commission on Graduate Medical Education and the New York State Public Health Council. He has served numerous national, state and city agencies in advisory and membership roles and has published extensively on hemodialysis, municipal hospital patient care and hypertension. Dr. Thomson received his M.D. from Howard University.

DORIS WETHERS

Dr. Doris Wethers is the Director of the Comprehensive Sickle Cell Program at St. Lukes-Roosevelt Hospital Center and also the Head of Pediatrics for H.I.P. Health Maintenance Organization in New York City. Dr. Wethers is a member of the American Academy of Pediatrics and the Susan Smith McKinney Steward Medical Society. She is a leading expert in the clinical research and patient care aspects of sickle cell. Dr. Wethers received her M.D. from Yale University.

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Dr. Kenneth Woodward is Manager of Clinical and Disability Services for Xerox Corporation. A Clinical Associate Professor of Preventive, Family and Rehabilitation Medicine and Senior Associate Pediatrician at Strong Memorial Hospital, he is also Clinical Associate Professor of Pediatrics, Preventive Medicine and Community Health at Rochester University School of Medicine. Dr. Woodward is a member of numerous local, national and international academic and professional organizations. Dr. Woodward has conducted research on patient care effectiveness of comprehensive health care centers and served on research review committees for the National Institute of Health. He has published articles in numerous professional journals on pediatrics, urban health services and health policy. Dr. Woodward received his M.D. from the University of Rochester.

The Health Subcommittee of leading professionals developed a broad multidimensional approach to the review of the health problems of the more than 2 million Blacks in New York State, the home of the nation's largest Black population.

The health status of Blacks was examined in each phase of the life cycle--maternal, infancy, childhood, adolescence, adulthood and the elderly years. The related issues of access and availability of medical care and affirmative actions to increase the number of medical and health care professionals to serve the Black community were also carefully considered by the Subcommittee.

A review of the data revealed that in New York State, as in the rest of the nation, the health status of Blacks has improved substantially, however, significant disparties continue to exist between Blacks and other New Yorkers.

The preliminary findings of the Subcommittee clearly establish the pernicious link between poverty and poor health. A complex interaction of socio-economic and behavioral factors have been found to adversely affect the health and longevity of Black New Yorkers.

An analysis of economic, social and health indicators supports the conclusion that Blacks -- of all ages -- are grossly overrepresented among the poor. More than one in four Black New Yorkers is poor compared to less than one in thirteen white New Yorkers.

This pervasive poverty recognizes no age boundaries. In 1985, the poverty rate among Black children age eighteen and younger in New York State was 41 percent, considerably higher than in 1980 (36.8 percent). Black children living in inner cities have higher rates of poverty than children statewide. For example, one of every two Black children

under sixteen years old in Buffalo, lives in poverty. Black elderly in New York State (49.5 percent) live at or below the poverty level: 29 percent below poverty and 20.5 percent in marginal poverty.

New York State has a much higher proportion of its poverty population concentrated in poverty areas than the nation as a whole.

More than half of the State's 2.4 million Black New Yorkers are concentrated in New York City (1,784,337); the counties of Westchester, Erie, Nassau, Suffolk, Monroe and Onondaga; and the major upstate urban cities of Buffalo, Rochester, Syracuse, Albany, Schenectady and Troy.

The Black poor are severely massed in urban areas which have substandard, overcrowded housing and hazardous fire, traffic, pollution and other environmental conditions. Their neighborhoods are plagued by drug abuse, crime, interpersonal violence and myriad other detrimental lifestyles.

These encumbered Black communities have reduced access to preventive health services as well as to acute and long-term care.

Low birthweight, infant mortality, chemical dependence and incidence of cancer and cardiovascular disease have a disproportionate impact on Black New Yorkers. While causal relationships cannot be established, the data link health status to living conditions.

The Health Subcommittee was influenced by the findings of the Federal Task Force on Black and Minority Health, which affirmed that

"lack of education and income are major factors for disease and death in Blacks." The review and analysis of data by each of the working groups of the Health Subcommittee fully supports this view.

Chapter 1, Equity in Black Health and Care in New York State, provides the context for looking at the health status of Blacks in New York. Documented is the fact that as the general health of the nation improves, gaps between the health status of Blacks and whites continue to signal disturbing disparities. While the fourteen-year life expectancy differential between Blacks and whites at the turn of the century has narrowed, white Americans can expect to live five and one half years longer than Black Americans. As in the nation as a whole, this disparate health status remains between white and Black New Yorkers. Evidence presented underscores the insidious relationship between lower socio-economic status and poor health.

Analysis of economic, social and health indicators supports the conclusion that Black New Yorkers of all ages are grossly overrepresented among the poor. Over 28 percent of New York State's Black residents had incomes in 1980 below the Federal Bureau of the Census definition of poverty, compared with 8.3 percent of white non-Hispanics. More than one in four Black New Yorkers is poor; less than one in thirteen white New Yorkers is poor.

Poverty among Blacks in the major cities is more severe than the state average for Blacks. The rates of poverty among Blacks in five of New York's major cities all exceed the statewide average for Blacks.

While more improvished Blacks reside in the greater New York City area, Buffalo has a higher percentage of Blacks with incomes below the poverty level.

In New York City, 86 percent of Blacks live in neighborhoods where 20 percent or more are poor, and 45 percent live in areas where 40 percent are poor.

Poverty recognizes no age boundaries. In 198[illegible], one of every four Black children eighteen years or younger was growing up in poverty. Black children living in inner cities, like Black adults in those communities, have higher rates of poverty than Black children statewide. For example, one of every two Black children under sixteen lives in poverty.

New York has a much higher proportion of its poverty population concentrated in poverty areas than the nation as a whole. More than three in four Blacks (76.1 percent) in the state live in central city poverty areas.

There is a significant and growing number of poor Blacks concentrated in central city poverty areas. This concentration is more severe in New York City where 86 percent of Blacks live in neighborhoods where 20 percent or more are poor, and 45 percent live in areas where 40 percent are poor.

A review of the literature on Black health suggests that four social characteristics are especially significant to health status:

1) demographic profiles
2) nutritional status and dietary practices
3) environmental and occupational exposures
4) stress and coping patterns

This chapter reviews the data on the six causes of mortality which together account for four of every five excess deaths of non-whites aged 70 and younger:

- cancer
- cardiovascular disease and stroke
- chemical dependency
- diabetes
- homicides and accidents
- infant mortality

The data was taken from national surveys and, with a few exceptions, the evidence suggests that the health of Blacks in New York does not differ significantly.

The Subcommittee analyzed several issues related to access and availability of medical care and service provision and emphasized the social and economic urgency for moving equity to the top of the health agenda. With regard to services, access, availability and quality this Subcommittee asserts that, in part, health status differences observed between Blacks and whites can be attributed to several indices of health care resources, health services utilization, health care financing, availability of health care facilities, personal and health knowledge and behavior. Blacks rely heavily on clinics, emergency rooms and hospital outpatient departments and make fewer office visits to physicians than do whites.

Approximately 16 percent of New Yorkers, eligible for Medicaid, did not use these services. About 40 percent of the poor are not enrolled in Medicaid. As family size increases, more typical in Black families than in white, there is a wider gap between the poverty level and Medicaid eligibility. Estimates suggest that in New York State:

- o 400,000 poor persons, including 100,000 poor children, are not covered by Medicaid or by private insurance.
- o 340,000 persons with incomes just above the poverty level fall into the gap in health coverage.
- o The poor or near poor (including those who work in part-time or in low paying jobs) are without health care coverage.

The implementation of Diagnostic Related Groups (DRGs), which provide a guide for length of hospital stay for some 468 specified diagnoses, negatively affect the Black elderly. Access to long-term care beds for Blacks has become an important issue as the number of Black elderly rises. A 1984 report revealed that while minorities as a whole represented 18.4 percent of the city's residential health care facility beds, they were overrepresented in public nursing homes, occupying close to 50 percent of the beds.

Only 14 percent of New York State's eligible children used the Child/Teen Health Services Program in 1982. Community Health Centers, formed two decades ago, were designed to offer an additional source of accessible medical care in poor neighborhoods. Less than 50 community health centers operate in New York State, treating only 500,000 of 2.2 million Medicaid eligible persons. A very recent development, the School Health Demonstration Program, with 14 upstate and 79 downstate sites, provides a comprehensive array of health services to more than 40,000 youth in the schools (K-12). The School Health Demonstration Program has been highly successful. There is a need to both expand and institutionalize the program.

In the discussion of human resources in service delivery it is pointed out that despite the increase in medical school enrollment, every major urban Black community in New York State is designated as a manpower shortage area -- having less than one doctor per 3,000 residents. By 1980 the ratio of physicians to population within the boundaries of East and Central Harlem had fallen to one physician per 15,000 residents. Individuals in these medically underserved areas were 36 times more underserved than individuals residing in New York City as a whole.

The Subcommittee asserts that the expansion of the supply of Black physicians and other health professionals should be a priority since doctors from minority backgrounds are more likely to serve patients of the same racial background. This affirmative action will require an increase in the number of Black physicians, the pool of Black medical school graduates and applicants and the rate of acceptance and retention of more students enrolled in medical school programs. Issues to be considered include deliberate efforts to recruit Black medical students and financial aid. The importance of early academic training and encouragement must be recognized.

Additionally, there is a severe dental manpower shortage in New York. Brooklyn and the Bronx had 62 of the City's 85 health areas with a dentist population ratio at or below 0.20 dentists per 1,000 population. Twenty-four of the City's health areas have no dentists in practice, eleven of these are in the Bronx.

The Health Subcommittee has developed the following initiative to coordinate health needs of Black New Yorkers.

DIVISION OF BLACK HEALTH

- o **The State should establish a permanent Office of Black Affairs with a Division on Black Health to address the health and health-related needs of Blacks. The Black Health Division would support existing facilities and programs and initiate the development of new programs by local organizations and corporations. The Division would have a policymaking, coordinating and monitoring function with direct links to the Executive Office.**

HEALTH SERVICES

The Subcommittee identified problems in each phase of the life cycle and developed corresponding health service recommendations. These recommendations address the need for quality, accessible community-based comprehensive health services, with an emphasis on preventive care, and are included in the categorical life cycle sections of the report. The following recommendations of the Health Subcommittee cut across the life cycle, impacting health services for Blacks of all ages.

- o **The State should support community-based comprehensive health centers and the effort to make preventive health care accessible to the medically indigent in the Black community. In addition, hospitals and community-based clinics that serve predominantly Black populations should be supported in developing, providing and expanding a full range of comprehensive health services.**

There are significant gaps in access to services and in the availability of health care in poor Black communities. For example, there are less than 50 community health centers operating in New York State, treating only 500,000 of 2.2 million Medicaid-eligible persons.

About 40 percent of the poor, 400,000 persons, including 100,000 children, are left uncovered. An additional 340,000 persons with incomes just above the poverty level fall into this same gap in health coverage.

- **The State should support some of the Department of Health's initiatives, including management assistance, additional financial support and the development of additional sources of capital for expansion of community-based comprehensive health centers.**

The diffusion of information aimed at ethnic and culturally diverse populations is more likely to be successful if it is planned at the community level. A partnership must be developed between local communities and government. Ethnic communities need funding and technical assistance to identify their own problems and develop their own culturally relevant methods of solving them.

- **The State should develop innovative approaches to motivate Black families to seek preventive care, i.e., use of home visitors. Soliciting the technical assistance of Black community-based organizations in this regard is imperative.**

- **The State should ensure that health information is disseminated in the Black community and should improve and expand its outreach programs.**

The Governor's Medicaid Reform strategy for developing a systems approach to foster preventive medicine and develop community health clinics discourages episodic and fragmented care. The following recommendations would better serve the Black community.

- **Expand Medicaid eligibility to 100 percent of the poverty level for families of all sizes. The program could then draw into an insured pool thousands of poor New Yorkers who presently have no health insurance coverage.**

- o Extend medical insurance, through Medicaid or some other form of social insurance, to the working poor.

- o Increase Medicaid reimbursement fees to retain and to encourage the participation of private physicians and specialists in the program.

- o Decrease Medicaid recipient reliance on hospital emergency room, outpatient department care and shared health facilities by developing opportunities for preventive care and private physicians services or other forms of prepaid enrollment plans. This measure would be instrumental in helping to achieve the objective of case-managed, preventive care.

The major contributors to the disparities in health status between Blacks and non-Hispanic whites have been identified--cancer, cardiovascular disease and stroke, chemical dependency, deaths due to cirrhosis, diabetes, homicides and accidents and infant mortality. For example, Blacks are less knowledgeable about cancer-related warning signs and screening methods resulting in their longer delay in seeking diagnosis and treatment.

- o The State should initiate public health and information campaigns focused on a variety of behaviors -- smoking, diet, the importance of prenatal care and timeliness in seeking care -- as important preventive activities related to specific diseases.

- o The State should set priorities through State funding allocations via specific targeting by disease, program and ethnic group in greatest need.

HEALTH MANPOWER & EDUCATION

Minority access to health careers has not improved over the last decade. New York State has lagged behind the national average in the number of minorities enrolled in most health professional training programs.

- The State should implement those recommendations proposed by State Task Forces that would facilitate increasing the number of Black physicians and specialists practicing in the State, including those proposals: to strengthen the early academic preparation of Black students; to disseminate information on health career opportunities to Black students; to review medical school admissions criteria; to increase the pool of Black medical school applicants; and to expand medical school recruitment, financial aid and retention of Black students.

- The State should implement an aggressive plan to increase scholarships and to waive the income eligibility requirements for low-interest health career education loans for underrepresented Blacks. Concurrent efforts should be put forth for the training and development of Black faculty.

  The State should mandate State University of New York (SUNY) Schools of Medicine, Nursing and Allied Health to recruit and retain more Black faculty and encourage the recruitment of Black faculty in other health-related schools in New York.

Federally sponsored programs and incentives from 1964 to 1974 expanded opportunities in health care to Blacks. Black enrollment in medical schools increased from 1,042 or 2.8 percent of the total enrollment during the period 1969-70 to 3,884 or 5.9 percent of total enrollment between 1981-82. The number of Black practicing physicians nationwide only rose from 2.1 percent in 1950 to 2.6 percent in 1980 -- 4,026 to 11,700 physicians. This growth did not keep pace with the increases in the State's Black population. The ratio of physicians to population within the boundaries of East and Central Harlem was less

than one physician per 7,000 residents and 6,000 residents, respectfully in 1978. By 1980, the ratio in these two areas worsened, falling to one physician per 15,000 residents.

Institutions that have traditionally been responsive to the needs of the Black community, such as City University of New York and the Sophie Davis School of Biomedical Education, should be supported with a substantial resource commitment that will enable them to continue and expand programs. These training institutions provide the opportunity for early academic training and encouragement as well as academic preparation for Blacks interested in the health professions.

New ways of organizing and financing health care, the changing role of hospitals as the major provider of ambulatory care and the keen competition with the private sector for secondary and tertiary services have jeopardized the very existence of institutions with a history of serving predominantly Black communities. As the major American institution for post graduate training of Black physicians, Harlem Hospital has made a monumental contribution to medical education and clinical research. This hospital continues to provide high-quality medical care to the community and to the working poor who must pay for their own care and are rejected by the voluntary health agencies in New York City. It is the major health care facility in the Central Harlem catchment area. To Black youth nationally, it remains the ideal place to train for careers in medicine and the allied health professions. To better meet these needs, greater support from outside sources are essential for survival of the Harlem Hospital Center.

- **Funds should be appropriated for the support of institutions such as Harlem Hospital, to train physicians, nurses and other allied health professionals, thereby facilitating smoother entrance for Blacks into health careers.**

The Commission on Graduate Medical Education provides incentives to New York medical schools to accept more minority students. These schools should implement an affirmative action policy to increase the pool of applicants, to increase the rate of acceptance and to retain students who enroll in medical school programs.

- **A State Council on Career Opportunities in The Health Professions should be established to provide a focus for State efforts to increase the number and proportion of Blacks in medicine, nursing and allied health services.**

- **The State should strengthen the recruitment and retention programs for Blacks in existing health programs in New York at the college level, professional level, high school level and junior high school level. Funding should also be allocated for peer support groups to encourage retention.**

There is gross underrepresentation of Black medical students in New York State. There is also a severe dental manpower shortage. All the professional training programs in health in the State University of New York (SUNY) system show minority enrollment of less than 10 percent. Indeed, most programs show such enrollments below five percent. The thrust toward decreasing enrollment in medical education as well as in other areas, clearly should not include enrollment of underrepresented minorities.

- **The State should review the present thrust to curtail the use of foreign medical school graduates to ensure that qualified foreign medical students, particularly Blacks trained at African and European schools and the University of the West Indies, etc., are not eliminated.**

- o The State should establish an office whose primary responsibility would be to collect, analyze and disseminate information on the representation of Blacks in health manpower. The office would be a permanent part of the State Department of Health. Data should relate to the life cycle and correspond directly with the number and categories of health providers required in each phase.

SUNY'S record on minority enrollment in the health professions program is unacceptable. There is a large pool of minority students from which applicants can be drawn. Given the public funds going to support the University, SUNY should be held accountable for its performance in supporting the social and health policy goals of the State. The State should require improved performance by the State University.

- o State financial support for educational inistitutions should be linked with the performance of these institutions in the enrollment and retention of Black students. The State must also develop career paths for Blacks in the health professions.

Chapter 2, The Development of Black Children in New York: Selected Issues in Maternal Infant and Child Health, focuses on the disparities that continue to exist between Blacks and other New Yorkers with regard to maternal and infant mortality, prenatal care, prematurity, low birthweight, nutrition, immunization and child health care.

The link between poverty status and low educational attainment of Black women has been established. Furthermore, the education of mothers is linked to the high-risk health status of mothers and children. At the same time, access and availability of care is also determined by the ethnic and socio-economic status of Black mothers and their children.

This chapter of the Subcommittee report emphasizes the responsibility of government at every level to allocate resources and insure access and availability of care, especially to the poor.

Maternal health indicators, like those of children in New York State, reflect racial disparities. In 1984 the maternal mortality rate for Black New Yorkers (3.6 per 10,000 live births) was more than two and one half times that of whites (1.3 per 10,000 live births). Maternal factors associated with high-risk infant mortality include:

- o age -- under 17 years and over 35 years
- o residence in impoverished communities and the associated low level of educational attainment
- o substance abuse, -- of 3,000 infants served through the Infant Health Assessment Program in New York City, 30 percent are with mothers that show evidence of substance abuse
- o late or no prenatal care -- the greatest single cause of infant mortality

Access is a major issue in the area of maternity care. Maternity care includes prenatal care, nutrition, genetic counseling, labor and delivery, interconceptional care, family planning and postpartum medical and hospital services. The Institute of Medicine's Committee to Study the Prevention of Low Birthweight identified the following barriers to early prenatal care:

- o financial constraints such as inadequate insurance or lack of Medicaid funds to purchase care
- o limited availability of maternity care providers, particularly providers willing to serve socially disadvantaged or high-risk pregnant women

- o insufficient prenatal services in some sites routinely used by high-risk populations, such as community health centers
- o experiences, attitudes and beliefs among women that make them disinclined to seek prenatal care
- o poor or absent transportation and child care services
- o inadequate systems to recruit hard-to-reach women into care

Financial factors pose major barriers to maternity care in New York State. The State Department of Health estimated that 44,000 women, largely in the New York City area had limited or no access to prenatal services. Thousands of poor or near poor women were denied access to maternity services because of Medicaid eligibility standards. They were also unable to participate in the Women, Infants and Children (WIC) program which reaches only 46 percent of those potentially eligible. WIC, a special supplemental feeding program can improve nutrition, reduce the risk of low birthweight and has been proven to benefit infants and preschoolers in a variety of positive ways.

There are also problems of access and availability of family planning services for Black women in New York. The State contributes 12 percent of the funding for family planning and the State Department of Social Services administers Medicaid and Social Services Block Grants. Family planning is a type of primary health care that emphasizes health promotion, particularly reproductive health care, maintenance and education. It often serves as a point of entry into the health care system, particularly for poor women. Induced abortion

increases the intervals between births to high-risk women and has been the greatest contributor to the decline of Black neonatal mortality. Many Black women are unserved. Of the 354,000 women in New York who received family-planning services in 1983, only 20.9 percent were Black.

Infant survival (beyond the first 28 days of life) is also dependent on a complex set of interrelated environmental and socio-economic factors. While infant mortality has declined in the past decade for all groups, the disparities between Black rates and those of other New Yorkers remain. In New York State the Black infant mortality rate in 1984 was 17.4 per 1,000 live births, nearly two times higher than that of whites. Neonatal mortality for Black infants was 10.7 per 1,000 live births, nearly two-thirds higher than that of whites. Central Harlem has the highest statewide infant mortality rate, 27.6 per 1,000 live births. Moreover, in New York City the infant mortality rate associated with narcotic use increased from 42 per 1,000 live births to 52 per 1,000 live births from 1976 to 1983.

Data in this chapter of the report document the concentration of health problems among children in impoverished, predominantly Black and Hispanic neighborhoods. Access and availability of basic health services, including prevention, screening and treatment, are crucial for proper growth and development of Black children. Problems evidenced in Black children include poor nutrition, resulting in obesity and iron deficiencies, improper dietary habits of excess salt, fat and sugar consumption and insufficient fiber intake. Poor immunization is a problem. Nationally, less than half of all poor and

minority children under age four are fully vaccinated against preventable infections. New York State does not collect this data by race.

Special health problems which plague Black children include lead poisoning, sickle cell anemia, accidental death (17.8 per 100,000 versus 12.4 per 100,000 for whites in 1983), risk of physical and developmental problems in children 0-5 years of age because of one or a combination of problems -- low birthweight, mother's age (less than 16), prematurity, sickle cell disease, major congenital anomalies, neonatal infections and maternal substance abuse.

MATERNAL HEALTH

A concerted State effort is required to ensure that Black women in particular obtain the care needed for their own physical well-being and that of their infants and children. In the area of maternal health the Subcommittee places primary emphasis on the promotion of early and consistent use of prenatal care by all pregnant women.

- **The State should ensure universal access to prenatal care services and support and initiate the development of appropriate, accessible, culturally compatible services. In addition, the State should develop on-going means of monitoring the efficacy of the regional perinatal networks.**

In 1983 New York State ranked 46 out of 51 states for Black women receiving early care and 47 out of a rankable 48 non-white women receiving late or no prenatal care. In 1984 the maternal mortality rate for Black women was more than two and one half times that of whites. The State's Black infant mortality rate in 1984 was nearly

twice that of whites; neonatal mortality for Blacks was nearly two-thirds higher. The relationship between early prenatal care and normal birthweight has been established.

The WIC program, which in New York State reaches only 46 percent of those potentially eligible, has contributed to lower rates of prematurity, fewer stillbirths, better health and improved intellectual development of younger children.

- **The State should implement a comprehensive strategy to develop non-traditional approaches targeted to Black mothers, to encourage them to seek early prenatal care. This program should include a strong parent and nutrition education component of the WIC Program, and should encourage Black women to consider breastfeeding.**

- **The Subcommittee fully supports the recommendation of the Department of Health and Human Services 1990 Objectives for the Nation report to develop, implement and evaluate health education (through work sites, schools, mass media, etc.) on the avoidable risks to maternal and fetal health during pregnancy, i.e., poor nutrition, use of alcohol, cigarettes and drugs, and the importance of breastfeeding.**

Black women living in impoverished communities (25.7 percent of New York State's Black families live in poverty areas) are likely to have low levels of educational achievement. Culturally sensitive, community-based efforts targeted to women in such communities have demonstrated their effectiveness.

INFANT HEALTH

In the area of infant health the Subcommittee focused on the newborn through the first year of life. Newly emerging concerns include "boarder babies" (any infant who stays in a hospital beyond the time that they require medical care) and AIDS babies.

In view of the increase in the number of babies requiring care (due to the increase in the problems of their parents such as chemical dependency and child abuse, the housing crisis and changes in eligibility criteria for public assistance) New York State's policy to "shrink" the foster care system must be reversed. The New York State Department of Social Services is responsible for assessing the needs and planning with local communities. Low salaries and inadequate compensation and support for foster parents have been identified as barriers to recruitment of foster parents. There has been no systematic study of the number of "boarder babies" due to "crack," nor the specific health and developmental problems resulting from parental use of "crack."

- o **The State should provide adequate supports which would increase the willingness and ability of Black families to provide foster care. In addition, the State should make available preventive mental health services to avert retardation.**

Additional recommendations in the area of infant health would include the following:

- o **Address the needs of infants at medical and/or social risk for physical and/or developmental problems (i.e., infants with AIDS or genetic problems, etc.) by increasing the funding available for the Infant Health Assessment Program (IHAP) which currently meets only 60% of need.**

- o **Ensure universal access for infant health care services, including expanding access to the WIC program and immunization services. This will also require non-traditional approaches to outreach.**

CHILD HEALTH

In the area of child health the Subcommittee identified immunization, nutrition and day care sanitation as priority issues. Immunization is the most effective prevention for the common infections of childhood and their often disabling complications. Among poor and minority children under age four, national data indicate that less than half are fully vaccinated against preventable infections.

- **The State should ensure immunization of toddlers in and out of day care programs for Hib, MMR, polio and DPT. The State should also ensure increased availability of free vaccines to primary health care providers in high-risk areas.**

As a result of issues of access, availability and utilization patterns, less than half of all poor and minority children in the nation are fully vaccinated against the preventable infections of childhood diseases. New York State does not keep immunization data by race. Black children, in particular, are less likely to receive comprehensive pediatric care or annual health care checkups.

- **The State should expand the current State funded school demonstration project models into permanent programs in elementary schools, where low cost or no cost primary health services are not readily available. These programs should be institutionalized so that they are available in all high-need communities across the State. This may require changes in both health and education statutes and will require additional State funding.**

There has been an increased demand for day care services at the same time that budget cuts have resulted in staff reduction. Poor

hygiene practices in child care settings used by many Black families (e.g., lack of toilet training among the youngest children, frequent handling of multiple children by care-givers and the tendency of young children to put hands and other objects in their mouths) combine to increase the risk of the spread of childhood infections.

- o **The State should ensure improved sanitation standards (good hygiene practices) in day care programs. Small group settings should be encouraged.**

Problems of poor nutrition are pervasive among Black children, including obesity, iron deficiency and the improper dietary habits of excessive intake of salt, fat and sugar and insufficient fiber consumption. Black mothers show a low tendency to breastfeed. These longstanding issues can effectively be allieviated.

- o **The State should provide adequate health education for day care and WIC program staff and families on nutritional and genetic issues, particularly obesity, iron deficiency and sickle cell anemia. The State should expand its nutrition education efforts and food supplementation as needed, particularly to address obesity and iron deficiency in Black children.**

A study conducted by the National Center for Health Statistics from 1979-81 revealed that 39.8 percent of Black children in the New York City area had not seen a dentist in the past year.

- o **The State should increase access to dental health services for Black children who do not receive regular dental care.**

Chapter 3, Risk-Taking and Resilience: Troubled Youth in Transition. The Health Implications for Adolescents, discusses the stressful social context which influences the development of Black adolescents and contributes to alienation and hopelessness among many poor Black youth. Alienation from society manifests itself in a number of serious problems ranging from early childbearing, dropping out of school, juvenile delinquency, violence, drug and alcohol abuse.

For many Black youth in New York the normal stresses and tasks of adolescence are made more difficult by the combined influences of unemployment, a degrading public assistance system, a failing educational system and inadequate access to both preventive and curative health services. There are four major tasks which adolescents confront during this period of transition to adult life: (1) developing a sense of pyschosexual identity, (2) resolving the conflicts between dependence and independence, (3) development of a system of values and (4) choosing a vocation (Christmas 1976). Teenage pregnancy and parenting, substance abuse and the use of drugs, particularly, combined with stress-related mental illness and interpersonal violence, pose the most serious challenges to positive youth development. Health is a critical component of this process.

This section of the Subcommittee's report provides an overview of the health status of Black adolescents.

- In New York State's inner cities, one in two Black children lives in poverty (1985). Seventy-six percent of the State's Black children under 21 live in New York City.

- The New York State 1980 Census documents that only 41.5 percent of Black teens lived with two parents.

- Unemployment among Black males 16-19 years is 40 percent in New York compared to 18 percent for white male teens.

The Subcommittee found that increasing rates of homicide and suicide, substance abuse, teen pregnancy and childbearing reflect the interrelationship between adolescent development and issues of race and poverty. For many Blacks, limited access to and poor utilization of primary care and preventive health services often result in adverse consequences for the process of adolescent development. Indeed, health indices of adolescence support the conclusion that Black adolescents are worse off in the 1980s than in the 1970s. It is against this background that the Subcommittee examined the issues of adolescent pregnancy, homicide, suicide and substance abuse.

ADOLESCENT PREGNANCY

Teenage parenthood has become a problem of great concern. Births among teens have declined in recent years; however, the incidence of sexual activity and the rates of pregnancy, particularly among younger teens, have continued to climb. In 1984, nearly 92 percent (9,376) of all births to New York State's Black teen mothers were out-of-wedlock, an increase from 66 percent in 1972. In 1984, 20 percent of all births in New York State occurred to non-Hispanic Blacks -- one in every five Black babies had a teenage mother.

The majority of births to Black teenagers (73 percent) occur in New York City. Of all teenage pregnancies in 1984, 38 percent (22,709) were to Black teenagers and 60 percent (35,858) were to white teens. Fifty four percent (912,369) terminated their pregnancies by abortion and 45 percent (910,226) carried their pregnancies to term.

Black teens are less likely to use contraception than their white peers. However, while there is an apparent lack of motivation to delay pregnancy, many Black teen pregnancies are unintended. When they do use contraception, Black teens tend to rely on medically prescribed methods (the pill, IUD) and resort to abortion as an alternative to these contraceptive methods.

Limited access to and low utilization of prenatal services lead to poor health outcomes for both the mother and the baby; 26.9 percent of Black teen mothers received late or no prenatal care. In view of the association between prenatal care and low birthweight it is not surprising that 23 percent of all low birthweight babies in New York State were born to Black mothers.

Early pregnancy and childbearing have other serious and often intractable outcomes. There is a common perception that pregnancy precedes dropping out of school. However, a number of recent studies provide evidence that a significant proportion of Black teen mothers have dropped out of school <u>before</u> becoming pregnant. Early childbearing is associated significantly with longer dependence on public assistance. A recent study showed that a non-white high school dropout who starts receiving welfare as a single mother will average approximately ten years of Aid to Families With Dependent Children

VIOLENCE

In 1984, Black males 10-19 years were murdered at a rate thirteen times higher than that of white males. Among Black teenage girls (13-19 years) 25 percent of all deaths were a result of murder compared to nine percent for their white counterparts. Prevention of interpersonal violence and homicide in Black youth requires an understanding of adolescent development, poverty and racism. The anger resulting from these pressures appears to contribute to the overrepresentation of Black youth in interpersonal violence.

Suicide is not one of the five leading causes of deaths among Blacks 13-19 years, however, the incidence of death from suicide rises for Blacks between the ages of 18 and 24. Children and youth who are at increased risk of committing suicide include those with a history of serious psychiatric disorders, drug and alcohol abuse, depression, a sense of failure or alienation. Indeed, drug and alcohol abuse may be disguised attempts at suicide which result in drunk driving, accidents and overdoses.

SUBSTANCE ABUSE

Drugs, alcohol and tobacco use are serious problems among teenagers. The rate of increase for new smokers is greatest among Black adolescent women. The New York State Division of Substance Abuse Services recently studied Black students in grades 10 through 12. Among the findings:

- Forty-five percent of Black students had used one or more select substances and/or used psychoactive prescription drugs nonmedically in the six months prior to the survey;
- Nineteen percent of Black students are considered to be regular or heavy substance abusers;

- o Black students had the highest rate of marijuana use, 37 percent;
- o Cocaine, a highly addictive drug, is commonly used among adolescents following marijuana and amphetamines.
- o Extensive use of "crack" is reported in New York City and Westchester.
- o Alcohol is used less often among Black students than among students as a group statewide.

There is a common perception that teenage mothers are giving birth to babies addicted to "crack." The head of Harlem Hospital's Mental Health Intensive Care Unit recently reported that the average age of mothers who give birth to cocaine addicted babies is 25 1/2 years. The average age for intravenous drug users is 23 years. Only 8 percent of drug abusing mothers are teenagers.

ADOLESCENT HEALTH

In the area of adolescent health the Subcommittee identified the increasing rates of homicide and suicide, teen pregnancy and substance abuse among Black youth as priorities. Therefore, an overall focus on comprehensive health care, including school health programs and preventive day treatment programs is recommended. It is suggested that a comprehensive model addressing a range of needs and providing a range of health, social service, recreational and skills development activities would be appropriate.

In order to meet the challenge created by this growing crisis among Black adolescents, as well as young adults aged 18 to 24 years (the latter group being in particular need of services because of

their "aging out" status in the traditional mental health delivery system), creative approaches to service delivery for this population are required.

- o **The State should develop comprehensive adolescent health and mental health service programs in New York City (specifically Harlem and Bedford Stuyvesant), Westchester and Buffalo. These programs, under the auspices of a community mental health and/or health center with appropriate linkages to schools, hospitals, etc., would be multifunded, focusing on early identification of at-risk youth with an emphasis on prevention--including prenatal care, health and social services, crisis counseling and education.**

The Door in Manhattan is an excellent example of the type of comprehensive adolescent health services program which should be encouraged and supported as an institutionalized component of the adolescent health system in Black communities. In New York City the Council's Center for Problems of Living has developed a proposal for a comprehensive regional program model for Black youth, which would include targeted services in the lower Bronx, Inwood, West Harlem, Washington Heights and Central Harlem.

Increasing accessibility to and utilization of health services among Black adolescents must become a State priority.

- o **The State should develop a demonstration program of "presumptive eligibility." Such a program would presume all adolescents in specific geographic areas eligible for at least a first primary care visit. Presumptive eligibility would eliminate means tests and determine eligibility based on residence in areas with low socio-economic indicators.**

Alternatives to traditional health services for Black adolescents should be designed to address the socio-economic context and the critical stresses which influence their adolescent development and transition to adulthood.

- **The State should provide alternatives to traditional mental health services to Black adolescents and young adults, for whom such services might otherwise be unavailable (i.e., truants, high school dropouts, homeless and/or shelter-based youth, etc.) A variety of coordinated interventions and comprehensive programs should include but not be limited to a) walk-in and crisis psychiatric services, b) parenting groups for teenage mothers and fathers, c) family support services, d) short-term counselling, e) alcohol/substance abuse counseling, f) educational/vocational and general life skill development services.**

Black youth face serious social pressures living in depressed communities. There is growing alienation from society which manifests itself in a number of problems -- pregnancy and childbearing and homicide for example, suicide and substance abuse. Socio-economic pressures put Black adolescents at highest risk. It is the responsibility of government to assist them in their developmental tasks in order to facilitate the transition to adulthood. Preventive mental health services should include programs that enhance life options including life planning skills, role model and mentoring programs, programs to improve school performance and youth employment programs.

- **The State should develop program models for Black adolescents and young adults who, while not suffering from a clearly defined diagnosable "mental illness," nonetheless are deficient in basic social, education, vocational and general life skills.**

Chapter 4, The Productive Years of Life: Select Causes of Morbidity and Mortality Among Black Adults in New York State, focuses on the social and economic pressures which impact on the health status of Black adults who survive the hazards of childhood and the hurdles of adolescence. The health disparities between Blacks and other New Yorkers continue through adulthood. The leading cause of death for Blacks in their twenties in New York is homicide. For Black men in their thirties the leading cause of death is AIDS followed by homicide. For Black women who die in their thirties, most deaths are caused by cancer and cirrhosis of the liver. The leading causes of death for Blacks over the age of 39 years are heart disease and cancer.

In 1984, New York State Department of Health data on age - sex - race specific death rates show a number of striking statistics:

- The death rate of Black men in their thirties is more than four times the rate of their white counterparts.
- For deaths due to heart disease, Black men in their thirties die at a rate nearly three and a half times that of whites.
- For deaths due to cerebrovascular disease, Black men in their thirties and fifties die at a rate five times that of whites. For Black women in their thirties, the death rate is over seven times that of their white counterparts.
- For deaths due to cirrhosis of the liver, Black men in their thirties die at a rate nearly eight and a half times greater than their white counterparts. Black women die at a rate six and a half times greater than their white counterparts.
- For deaths due to AIDS, Black men in their thirties die at a rate nearly six times that of whites, while Black women of the same age die at a rate over 22 times greater than the rate of white women.

This chapter discusses the factors and issues associated with the morbidity and mortality rates and the health disparities between Black and white New Yorkers for the leading causes of death: cardiovascular and cerebrovascular diseases, cancer, cirrhosis of the liver, diabetes, acquired immune deficiency syndrome (AIDS) and tuberculosis.

Mental health issues are also addressed in the chapter.

Access to care is an important issue relating to these diseases. Blacks make fewer hospital visits and are less likely to be seen by a specialist or undergo coronary bypass surgery. Reliance on hospital clinics and emergency rooms mitigate against continuity of care.

Factors contributing to poor cancer survival in Blacks include lower socio-economic status and delay in detection and treatments. A number of studies support the hypothesis that the difference in the cancer experience of Blacks and whites may be largely attributable to social and environmental factors, including a greater exposure to toxins in the workplace. Tobacco, alcohol and nutrition are also major contributors. Among Blacks nationally, tobacco-related cancers account for approximately 45 percent of cancers in men and 25 percent in women.

Alcoholism is a major cause of cirrhosis of the liver. In New York State the mortality rate for Blacks due to cirrhosis of the liver is several times greater than that of whites at every age level.

According to the New York State Department of Health, approximately 4.5 percent or 107,850 individuals have diagnosed diabetes, and 4.4 percent or 105,688 may have undiagnosed diabetes. It

higher than that of whites. The risk of diabetes in Black women is twice the risk for Black men and is directly related to obesity. All diabetics are at increased risk for hypertension.

AIDS is rapidly becoming the most devastating disease to impact the Black community. Most cases of AIDS among Blacks result either directly or indirectly from intravenous drug use. Aside from homicide, AIDS has been the leading cause of death in New York City's predominantly Black neighborhoods. The Subcommittee on Human Services of the Governor's Advisory Committee for Black Affairs has done an in-depth analysis of the social service issues related to AIDS in the Black community in Volume 2 of the Advisory Committee's report series.

The rate of tuberculosis (TB) for Blacks greatly exceeded the average rate for New York State, New York City and upstate New York in 1985. For New York State, the average tuberculosis rate was 14.0 per 100,000; for Blacks it was 50.6. New York City had an average rate of 26.1; for Blacks it was 57.9. The upstate tuberculosis rate in 1985 was 6.1; for Blacks it was 29.5. In 1985, the tuberculosis rate increased to 26.1 cases per 100,000 population in New York City, from 22.0 per 100,000 in 1982.

ADULT HEALTH

The health problems which affect the Black adult population with greatest prevalence are conditions which, to a large extent, are either preventable or amenable to effective early detection and or

intervention. The increasing incidence of AIDS, cancer, hypertension, stroke, diabetes mellitus, chemical dependence and its complications are foremost in this population, and are responsible for morbidity which can be significantly reduced.

- **The State should develop statewide comprehensive community-based programs targeted at the aforementioned problems via screening, data collection and prevention.**

- **The State should provide improved access to health services by improving and expanding services and/or facilities in underserved areas. Priority for expansion should be given to existing providers with a history and track record for service provision in the Black community.**

There has been a substantial decline in the real value of welfare allowances as New York State benefit levels have failed to keep pace with inflation. AFDC caseloads have remained constant while the number of individuals living below poverty has risen. In New York City, official poverty rose from 15.5 percent of families in 1976 to 21.6 percent in 1982. Thus, the number of families eligible for Medicaid has not kept pace with need.

- **The State should modify existing Medicaid eligibility to expand the numbers of poor who would qualify.**

For Blacks in New York there are two groups of causes of death to be monitored: the leading causes that have historically accounted for many deaths and the emerging causes that now account for relatively few deaths, but are steadily increasing in numbers. Tuberculosis (TB) falls in the latter category.

Diffusion strategies aimed at ethnically, culturally diverse populations are more likely to be successful if they are planned at the community level, not at city, state or federal levels.

- **The State must develop a partnership between local communities and government. Ethnic communities need funding and technical assistance to identify their problems and develop their own culturally relevant methods of solving them.**

Although there is probably no single reason for the disparities in between Blacks and the rest of the population, mortality for preventable causes of death, it is likely that some of the reported differences in health status are a result of the limited effectiveness of past information diffusion efforts, developed with insufficient consideration and understanding of the cultural context, background and diversity of Blacks in New York (Lythcott 1986).

- **The State should mandate the development of an accurate data base on all ethnic populations in New York. The terms <u>minority</u>, <u>non-white</u>, <u>other</u> have become irrelevant in the collection and interpretation of vital statistics. Among Black New Yorkers, specific data on native born Blacks, Caribbean Blacks and Africans are more appropriate categories for health information reporting purposes. The Department of Health should develop the capacity to analyze data regarding the provision and effectiveness of services in the Black community.**

New York's homeless population is largely Black. Homeless Black families suffer from substantial stress, including isolation from their familiar neighborhoods, schools and other services. On-site services in shelters should provide supportive and preventive programs.

- **The State should fund and provide on-site service teams for homeless families in shelters. In addition to the State Office for Mental Health, the Department of Health, Department of Social Services, the Housing Finance Agency, Division of Alcoholism and Alcohol Abuse, Division of Substance Abuse Services, should each contribute to this effort to ensure continuity in programs and services. The on-site teams would offer a comprehensive-range of services using a case-management approach. Services would include mental health, preventive and general health care services as well as social services and recreational activities.**

AIDS had become the major cause of death in many of New York City's predominantly Black neighborhoods. The Human Services Subcommittee of the Governor's Advisory Committee for Black Affairs has prepared an in-depth analysis on the issue of AIDS in the Black Community in Volume 2 of the Advisory Committee's report series. Extensive programmatic and policy recommendations are offered in the Human Services Subcommittee report.

- **The State should immediately increase the representation of Blacks on planning and policymaking bodies, councils, and committees addressing the issue of AIDS.**

- **The State should immediately establish statewide programs to begin preventive educational and support programs for Blacks with AIDS.**

A study of narcotic deaths in 1985 revealed that 51 percent were Black and 77 percent were aged 25-44. Among Black men 20-60 years old, the mortality rate due to substance abuse is more than six times higher than that of white men and eight times higher in their twenties

and thirties than their white counterparts. Among Black women in their thirties the mortality rate due to substance abuse is six times higher than that of white women. Current program models do not meet the needs of Blacks, especially women.

- **The State should also increase the funds available to already existing drug and alcohol treatment programs and Black social service agencies with a history and successful track record in service to the Black community.**

Factors such as poverty, poor housing and the pressures of single parenthood create emotional stress in Blacks. A multifaceted mental health system providing culturally targeted and culturally-sensitive community programs would increase utilization of health and mental health services by Blacks. Programs which build on the strengths of the community would provide early identification, ongoing support and preventive mental health.

- **The State should establish crisis counseling centers and develop a range of day-treatment programs in the Black community.**

For the chronically mentally ill Black population there is a lack of residential facilities and programs to facilitate the transition back to their communities. There are few rehabilitative programs in Black communities.

- **The State should direct major mental health funding into the Black community for community-based services, specifically residential rehabilitative care and case-management services.**

Appropriate and adequate service cannot be developed without data about the mental health status of Blacks and their utilization of the mental health services system.

- **As recommended by the Minority Advisory Committee of the State Office of Mental Health, the State should establish an Institute for Mental Health Research and Policy on Racial Minorities. The State Office of Mental Health should be required to collect and analyze data by race and ethnicity.**

The Minority Advisory Committee of the State Office of Mental Health has found that racial and ethnic minority clients tend to be seen in the less expense treatment modalities of medication groups, group therapy, etc. There is an ongoing need for advocacy on behalf of racial and ethnic minorities within the New York State Office of Mental Health. In addition, there is also a need to reflect treatment outcome based on its cultural relevance to racial and ethnic groups.

In-service training and retraining are essential components of providing quality and appropriate mental health services. Culturally appropriate training and treatment modalities should be emphasized in mental health service programs. The tendency to use outside consultants from around the country, however, results in training which is more appropriate to other areas of the country. Black mental health professionals in middle management, research and administration could contribute to the development and implementation of culturally relevant mental health services. For example, research could focus on issues relating to poverty and discrimination and the mental health status of Blacks.

- **The State should identify Black mental health professionals for appointment to middle management, research and administrative positions.**

- **The State should initiate research on the design of mental health treatment programs that will address issues of particular concern to Blacks and encourage the use of Black researchers in State mental health consultant contracts.**

The Federal Task Force Report on Black and Minority Health found that chemical dependency, homicide, suicide, family violence, cardiovascular disease, stroke, hypertension, diabetes and its complications, infant mortality and cancer are illnesses which disproportionately affect Blacks. The aforementioned problems occur more substantially in Black mentally ill patients. Multiple diagnoses are prevalent in this population and the State must make targeted treatment of the Black mentally ill a priority.

- **The State should increase the availability and accessibility of preventive mental health services to providers of primary health care services in high - risk communities.**

Adult health problems in Black communities include neglect of personal health care, inadequate access to specialized services and insufficient health providers.

- **The State should subsidize the training of medical and allied health professionals who will serve Black communities and establish satellite clinics with simple registration procedures and hours convenient to the working adult.**

Chapter 5, Health Services for the Black Elderly: The Challenge Facing New York State, suggests that most aged Black people confront the same problems of their adult lives--poverty, poor living conditions, deteriorating physical strength and excessive morbidity and mortality.

New York State has the largest number of Black elderly in the nation and Black New Yorkers are living past age 65 at steadily increasing rates. From 1970 to 1980, the number of Black people over the age of 60 years in New York State increased by 40.1 percent from 175,049 to 245,304.

In 1983, life expectancy for Black males was 65 years as compared to 72 years for white males. The life expectancy was 74 years for Black females as compared to 79 years for white females. Nationally, Black men die from the leading causes of death of all elderly. The causes listed in descending order are: heart diseases, cerebrovascular diseases, cancer, accidents, pneumonia/influenza, chronic liver disease and diabetes. Black men died twice as frequently from liver disease and cirrhosis than white elderly men. Black women died of all the aforementioned diseases at higher rates than white woman.

The Black elderly are highly concentrated (49%) at and below the poverty level. In 1981, Social Security (47%) and Supplemental Security Income (10%) accounted for the majority of the income of Blacks aged 65 or older in the United States. Poverty increases the risk and severity of illness and lessens the likelihood that health

care services are available and utilized. Improper dietary habits and excessive drinking contributed significantly to the prevalence of morbidity and mortality among elderly Blacks.

Black elderly tend to rely on clinics and public hospital emergency rooms for health care. The New York City Department of Aging estimates that 20.5 percent of the Black elderly are without access to a physician; 28.4 percent of those sampled saw a doctor in a clinic rather than privately.

The majority of Black elderly do not have access to preventive care. Medicare primarily covers acute illnesses associated with hospitalization (70% of Medicare expenditures). The new payment system under Medicare reimbursement, Diagnostic Related Groups (DRGs), impacts negatively on the Black elderly, who generally represent more complicated and longer length of stay cases. The issue of access and premature discharge to impoverished living conditions are critical issues for this population.

Community-based support services are underdeveloped. Medicaid is the largest provider of home care services in New York State. However, many Black elderly hover just above the eligiblity level and do not have the personal resources to purchase home care.

In FY 1983, a growing proportion of Medicaid dollars (71%) spent on the elderly went to nursing home care. In 1985, Black elderly represented only 6.9 percent of New York State's nursing home population.

A recent review of informal support systems (family caretakers, etc.) revealed that the Black elderly cannot rely solely on these

resources. A study conducted by the New York City Department of Aging, found that 51.6 percent of the Black elderly in its sample had no children and 52.3 percent had only one child. Of all the elderly households in New York State below the poverty level, 77 percent are elderly persons living alone.

In the area of elderly health the Subcommittee identified the following priority issues: (1) organized legislative and individual advocacy on behalf of the Black elderly, (2) expanded training for elderly care providers, home attendants and home health care providers and (3) specialized housing for independent living.

- **The State should offer broad-based training and retraining, specialized training for home care workers, improved salaries for care providers and enforce standards to assure quality care.**

There is decreasing minority participation in aging services and programs although the minority population increased by over 45 percent between 1970 and 1980. Specific barriers to minority participation include an absence of providers with racial/ethnic backgrounds similar to those of the minority elderly, cultural attitudes and discrimination in institutional care. The needs of the Black elderly include preventive services, home care, comprehensive care for chronic and acute diseases.

- **The State should develop public service announcements (PSAs) targeted at the Black elderly and focused on available services. Collaborative efforts with public and private organizations, including Black churches, social and fraternal organizations, should be initiated to conduct a public education/ information campaign targeted at the Black community.**

Problems among the Black elderly include inadequate services for those who require minimal assistance but wish to remain in their own homes and the lack of information about and access to existing services. In addition, too few skilled nursing facilities are available for patients requiring acute nursing care.

- **The State should improve the quality of home care services and extend skilled nursing care to those elderly persons requiring acute care. The availability of acute care, access to nursing home beds and day care facilities in communities with predominantly Black populations of elderly should be increased.**

A study conducted by the New York City Department of Aging revealed that 20.5 percent of the Black elderly are without access to a physician and 28.4 percent see physicians in clinics, in contrast to 3.6 percent and 6.8 percent, respectively of white elderly. DRGs impact negatively on the Black elderly who are discharged prematurely and have little access to physicians or home care services in their communities.

- **The State should ensure that there are available short-term and long-term home health care services for the elderly with physicians or mid-level practitioners who would make periodic home visits, particularly to those elderly residing in predominantly Black communities. There is an even more critical need for nonmedical home care which must be made available and accessible in Black communities.**

There is a need to target health services to the elderly at the community level. The setting of a Senior Center could provide a culturally sensitive base for outreach and information sharing, for

improved access to and utilization of health services and for preventive services that address improper dietary habits and excessive drinking and smoking, which contribute greatly to the morbidity and mortality of elderly Blacks.

- **The State should develop a health program to place mid-level and allied health practitioners, trained in geriatric care, at Senior Centers located in predominantly Black communities.**

Medicare primarily covers acute illnesses associated with hospitalization. Medicaid currently serves only 23 percent of the eligible population and in FY 1983, 71 percent of New York State's Medicaid dollars spent on the elderly went to nursing home care. In 1985, the Black elderly represented only 6.9 percent of the state's nursing home population.

- The State should ensure increased access to and availability of services to the Black elderly with particular emphasis on acute care, nursing home care, chronic care, home care services and preventive services.